London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda

Wednesday 4 March 2020 at 7.00 pm
Main Hall (1st Floor) - 3 Shortlands, Hammersmith, W6 8DA

MEMBERSHIP

Administration	Opposition
Councillor Lucy Richardson (Chair) Councillor Jonathan Caleb-Landy Councillor Bora Kwon Councillor Mercy Umeh	Councillor Amanda Lloyd-Harris
Co-optees	
Victoria Brignell - Action on Disability, Action On Disability Jim Grealy - H&F Save Our NHS, H&F Save Our NHS Keith Mallinson - Healthwatch Roy Margolis Jen Nightingale	

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Hammersmith,
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Hammersmith

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Latymer Court (Stop G)

Date Issued: 25 February 2020

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Agenda

4 March 2020

Item		Pages
1.	**MINUTES OF THE PREVIOUS MEETING**	4 - 20

(a) To approve as an accurate record and the Chair to sign the minutes of the meeting of the Health, Adult Social Care and Social Inclusion PAC held on 27 January 2020; and

(b) To note the outstanding actions.

2. APOLOGIES FOR ABSENCE

3. DECLARATION OF INTEREST

If a Councillor has a disclosable pecuniary interest in a particular item, whether or not it is entered in the Authority's register of interests, or any other significant interest which they consider should be declared in the public interest, they should declare the existence and, unless it is a sensitive interest as defined in the Member Code of Conduct, the nature of the interest at the commencement of the consideration of that item or as soon as it becomes apparent.

At meetings where members of the public are allowed to be in attendance and speak, any Councillor with a disclosable pecuniary interest or other significant interest may also make representations, give evidence or answer questions about the matter. The Councillor must then withdraw immediately from the meeting before the matter is discussed and any vote taken.

Where Members of the public are not allowed to be in attendance and speak, then the Councillor with a disclosable pecuniary interest should withdraw from the meeting whilst the matter is under consideration. Councillors who have declared other significant interests should also withdraw from the meeting if they consider their continued participation in the matter would not be reasonable in the circumstances and may give rise to a perception of a conflict of interest.

Councillors are not obliged to withdraw from the meeting where a dispensation to that effect has been obtained from the Audit, Pensions and Standards Committee.

4. SPECIALIST PALLIATIVE CARE SERVICES UPDATE 21 - 44

The Committee will scrutinise the suspension of residential palliative care services at The Pembridge Hospice and in addition consider the engagement work undertaken by the CCGs to date on the provision of local palliative care services.

5. INCLUSIVE EMPLOYMENT UPDATE 45 - 55

To inform the Committee about progress to date on the area of improving the inclusive employment offer.

6. WORK PROGRAMME 56 - 58

The Committee is asked to consider its work programme for the remainder of the municipal year.

7. DATES OF FUTURE MEETINGS

24 March 2020

London Borough of Hammersmith & Fulham

Health, Inclusion and Social Care Policy and Accountability Committee

Minutes

Monday 27 January 2020

PRESENT

Committee members: Councillors Lucy Richardson (Chair), Jonathan Caleb-Landy, Bora Kwon, Mercy Umeh and Amanda Lloyd-Harris

Co-opted members: Victoria Brignell - Action on Disability (Action On Disability), Jim Grealy - H&F Save Our NHS (Save Our Hospitals), Roy Margolis, Keith Mallinson (Healthwatch) and Jen Nightingale

Other Councillors: Ben Coleman and Patricia Quigley

Officers: Vanessa Andreae, Vice-Chair, H&F CCG; Jo Baty, Assistant Director, Mental Health LD Provider; James Benson, Chief Operating Officer, CLCH; Olivia Clymer, Chief Executive, Healthwatch; Janet Cree, Managing Director, H&F CCG; Prakash Daryanani, Head of Finance (Social Care); Hitesh Jolapara, Strategic Director of Finance and Governance; Eva Psychrani, Engagement Lead, Healthwatch; and Lisa Redfern, Strategic Director of Social Care.

31. MINUTES OF THE PREVIOUS MEETING

RESOLVED

The minutes of the meeting held on 11 September 2019 were approved as a correct record and signed by the Chair.

32. APOLOGIES FOR ABSENCE

There were no apologies for absence.

33. DECLARATION OF INTEREST

There were no declarations of interests received.

34. APPOINTMENT OF CO-OPTEE

RESOLVED

The Committee agreed to the appointment of Roy Margolis as a co-optee.

35. REVIEW OF LOCAL PALLIATIVE CARE SERVICES - UPDATE

Councillor Richardson provided a recap setting out the Committee's consideration of the issue. This was the third time that members had considered the in-patient unit at Pembridge Hospice in the context of local specialist palliative care provision which was currently suspended due to the lack of a lead palliative care consultant.

Janet Cree referred members to the CCG paper which provided an update on the review of specialist palliative care services. A letter dated 17 January 2020 was sent collectively from all the CCGs commissioners and providers (included in the pack). The letter set out public engagement undertaken so far, and a summary of the work planned for the future model of care. Feedback had identified that there was an inequity of access to services across the four boroughs with only 48% of residents accessing specialist in-patient palliative care services. The Committee was informed that the CCG would be planning a programme of engagement and discussion once potential solutions had been published to develop a future model of care. The information would be collated and analysed to indicate whether a full consultation was required. Local overview and scrutiny committees would have an opportunity to provide feedback. The Committee was informed that the CCG was aware of what the in-patient unit at Pembridge meant to residents, but it had not been advisable to recruit during a period of transition, as set out in the letter. It was confirmed that the day patient service would remain open.

James Benson assured the Committee that providers understood the importance of the in-patient unit to residents but reinforced the CCG's view that it was not advisable to recruit during a period of transition and reiterated Janet Cree's earlier reference to the 17 January letter.

Co-optee Victoria Brignell asked if health colleagues acknowledged that there was a need for in-patient services at Pembridge. Janet Cree responded that this would be identified as part of the review of in-patient services and that critical to this was to achieve the right balance of services. Responding to a follow up point that the unit had been shut because the provider had been unable to recruit to the post, Janet Cree clarified that the recruitment process could not continue while the service was in transition. A potential candidate would have to take on a position in a service that was undergoing transition and that this would not be feasible or safe.

Councillor Lloyd-Harris queried the 48% statistic and asked why it was low as the figure implied that people were not aware of the provision. Janet Cree acknowledged that this anomaly was part of the issue that needed to be addressed. The current service was inaccessible or unavailable and one of

the outcomes that was hoped for was to ensure that uptake of the service was increased. Councillor Lloyd-Harris commented that residents needed to be informed because it appeared that the service was intentionally being run down with many obstacles that prevented progress toward a suitable resolution. Janet Cree countered that the main priority was to achieve the right service specification. It was explained that the CCG had tried to consider sharing a lead consultant but that even if a suitable person had been found the unit could not have been re-opened. James Benson added that the providers were unanimous that this was not feasible. The acute trusts had indicated that they did not have the resources available to support a 13-bed in-patient unit at Pembridge. They had explored alternative options for a lead consultant and in conjunction with the acute trusts a prospective appointee had been trialled, but this had been unsuccessful. It had been unsafe to continue and therefore he had agreed with the CCG to suspend recruitment. Co-optee Jen Nightingale suggested that there would still be a need for a lead clinician regardless of what the future service specification looked like. James Benson responded that there existed potential leadership within the community specialist palliative care service. The question was whether there was a need for separate leads for both this and the in-patient service, with a new model of care.

Councillor Richardson probed further and queried why there had been such sustained difficulties over an extended period. Janet Cree felt that it was not possible to explain the difficulties in recruitment, but the review had led to a shared position agreed by commissioners and providers which would be sustained until it was possible to recruit to the correct resource.

Co-optee Jim Grealy welcomed clarification that the CCG did not want to recruit during the review process but was aware that there were two phases during this process. He reported that he had attended an event at RBKC and had read the Penny Hansford independent review (also included in the papers). It appeared that in-patient beds of any kind had been ruled out as if the decision had already been made. He recommended that the CCG identify a way for the provider and the acute trusts to work together.

Jen Nightingale enquired what arrangements were in place to ensure that there was an out of hours service in place. James Benson explained that there was an on-call system in place cover for which was shared between nurse leadership team, provider and acute leads.

Co-optee Keith Mallinson queried the recruitment issue and asked what the difficulties in recruitment existed in London and within the home counties (Hertfordshire) given that they did not appear to have similar problems. James Benson replied that colleagues in acute trusts did have the same issues. He was aware the St John's Hospice had struggled but had managed to maintain their position. Many palliative care workers were employed part-time which was a positive given the operational requirements, but this was more than just a local issue and there were wider national concerns in parallel.

Councillor Quigley recounted her personal experience of Pembridge where her mother had been looked after in 2012. The care and support that her family had received had been much valued. She asked the CCG to explain what might have changed to such an extent since this time that had led to the current recruitment problem. James Benson welcomed Councillor Quigley's positive comments and stated that the CLCH had always been proud of the service offered by the palliative care team. This was a difficult situation however a decision was needed, and he could not offer any further insight as why it was so difficult to recruit at this time. In response to Cllr Quigley's further query as to whether this was because of the lack of qualified clinicians or if CLCH was refusing to recruit James Benson clarified that a key factor had been the sequence of events and the timing of when the vacancy had arisen. He reiterated the current position was to not recruit while the review was underway.

Councillor Bora Kwon questioned why a contingency plan had not been in place as it appeared precarious to run the unit without taking account of workforce changes. Councillor Kwon was unclear what efforts had been undertaken during this period and queried if there was an issue with the post that had prevented movement. Councillor Kwon suggested that lessons should be learned from this experience.

Councillor Freeman informed the Committee that RBKC had written to Central and West London CCGs to say that they while they recognised the challenges every effort should be made to keep Pembridge open. There was an expectation that the CCGs would work together to address the challenges around recruitment. Imperial College Healthcare NHS Trust and Chelsea and Westminster Hospital NHS Foundation Trust had confirmed that they were unable to stretch resources to provide the level of cover required however he hoped that a further meeting was planned with Chelsea and Westminster and which might be helpful. Referring to the RBKC event it was clear that the overwhelming response of residents was that the Pembridge was a service that was enormously valued, and it was important that it remained open. Pembridge was also one of the very few palliative care providers funded by the NHS in contrast to those which were funded by charities.

Councillor Jonathan Caleb-Landy queried why an issue over recruitment in the home counties was being viewed as a national crisis. He asked to what extent the CCG and CLCH had been working with others to resolve this. Councillor Caleb-Landy also sought further details about any contingency plans formulated given the lack of a replacement and enquired what allowances had been made to help people to travel to hospices in other areas such as St Johns or Trinity. He pointed out that each time this issue had been discussed the Committee had received incredibly powerful, personal testimonies about Pembridge. James Benson explained that two palliative care consultants were not needed to run a unit like Pembridge. Historically, when the in-patient unit had been closed, the contingency plan had been to share the lead clinician with St Johns. There were junior doctors and community consultants that could step in and he acknowledged a lack of foresight in not having a contingency plan in place. Initially they had felt that it might be possible to recruit, had offered accommodation and explored a wide

variety of options. They had also approached hospices that were closing but this was also unsuccessful. It was confirmed that given that they were not recruiting they had not therefore taken steps to speak with other providers. They had tried to work with multiple providers to recruit which the acute trusts had been aware of.

Councillor Richardson pointed out that it would have been helpful to have shared this information so that the Committee could understand the challenges. Janet Cree responded that Dr Joanne Medhurst had articulated this point at the previous meeting of the Committee. Councillor Lloyd-Harris added that it would have been helpful to have had this clarified to facilitate shared working but that it did not appear that this was intended.

Councillor Coleman thanked Councillor Freeman for the event organised at RBKC and for all his efforts. He referred to an earlier point that a potential solution might be identified by the beginning of February and asked if this would include in-patient services. Merril Hammer (H&F Save our NHS) commented that there was a need to find more radical and innovative solutions to address the shortage of clinicians without letting services disappear. Querying the statistic of 48% referred to during the discussion, it was reported that a clinician from Imperial at the RBKC event had stated that not everyone who was dying needed specialist palliative care support. However, the CCG had inferred that this was an issue attributable to the lack of patient outreach work. These were two distinct arguments to explain the low take up of services. Was this due to the lack residents requiring specialist care or because they were not aware of the service being available. It was pointed out that the Penny Hansford review had set up the foundation for potential conflict between care in the community and establishing an in-patient unit. This was not the case and those who had attended engagement events had made it clear that both were required. In a final point, the Penny Hansford report did not take into consideration local democracy or social factors. Pembridge was located in one of the most deprived areas of RBKC populated by large numbers of, single person households, vulnerable and elderly residents. A further question was why an NHS funded facility such as Pembridge had been targeted.

Janet Cree responded that their aim was to ensure that patients who received palliative care were ensured a smooth end of life. Much of end of life care took place within the community or in a nursing home and they did not all have access to specialist palliative care. The CCG wanted to ensure that the service was more widely provided. They sought to achieve a balanced provision that met the needs of in-patient care and community-based care services and to get this balance right. It was never intended to preclude in-patient beds from the review. Patients receiving palliative care in the community also had access to the in-patient service. There was good palliative care provision within the community but there was not always access to the specialist provision that would enhance that experience for family and friends. This is what the CCG hoped to address, and nothing had been predetermined within the review.

Councillor Coleman sought clarification about what the review entailed and if this meant that the CCG would work through the views already received, or would they undertake a consultation. Councillor Coleman also asked if the potential solution paper currently being drafted would form the basis of further consultation. Janet Cree responded that there was an on-going engagement process and referred to the 'What Next' section of the 17 September letter which was read out. Councillor Coleman probed further and suggested that the Committee might be able to consider some real ideas at its next meeting. He asked when the document would be available and if it would touch on the future of the in-patient's unit. Janet Cree replied that she had not indicated that it would "touch" on in-patients but would address in-patient access to specialist palliative care. The expectation was that the service would be offered as part of the whole range of provision for the local population. It was confirmed that the Committee would be included in the engagement process and that members would be able to scrutinise concrete proposals and solutions. Following further discussion, it was clarified that this document might be available at the beginning of February or at the latest, within two to three weeks.

James Benson referred to the point that had been made regarding the statistic of 48% take up and acknowledged that this was low however, not everyone required specialist palliative care and further work was required to understand this figure. Janet Cree added that this point could be made more clearly during the next stage of the review process and that this would be rectified in future briefings.

A member of the public reported that they had participated in the engagement workshops and was a member of the Tri-borough Residents End of Life Care Group. Pembridge Hospice was distinguished by the fact that it was wholly NHS funded and that creating a broad service that would meet the need of an increasing local population would have to be achieved within a limited budget.

Lisa Redfern observed that it was hard to identify what different skills were required by a lead palliative care consultant, supervising both community care teams and hospice staff. Whilst it was acknowledged that there were concerns about recruitment it was accepted that this was a difficult process to manage. The need for a lead consultant was queried. Janet Cree confirmed that a lead consultant was the only option and that a junior specialist clinician would not be appropriate. In reviewing the Hospice UK Workforce report Lisa Redfern was of the view that there did not appear to be recruitment difficulties. Concern was also expressed about capacity within the existing configuration, given the potential closure of Garside and the part closure of Pembridge, which indicated that this would be an issue across the four boroughs.

Julia Gregory, Local Democracy Reporter (Get West London and local democracy wire service) sought clarification about an aspiration to have 75% of patients receiving access to specialist palliative care services, a point that had been discussed at the RBKC event.

James Benson clarified that this point had been made by Professor Urch (Divisional Director Surgery, Cancer and Cardiovascular, Imperial College Healthcare NHS Trust) that 75% of residents should be able to access the service but that in his view, this was unlikely to reach 100%. There was a fundamental difference between nurses in the community and the in-patient unit which required specific leadership. An additional complexity was that if the unit operated with a shortage of clinicians. This required cover to be provided by either St Johns or St Elizabeth's which they could not do. Operationally, having inconsistent cover would not work and would present significant challenges in running the unit. An in-patient unit like Pembridge would expect to see more complex cases and would therefore need an experienced lead consultant.

Addressing the point raised by Lisa Redfern on capacity, Janet Cree commented that Garside care home currently had suspended admissions due to quality issues but had recourse to alternative provisions elsewhere with the system. In the interests of transparency James Benson commented that additional support was being provided to assist residents while they remained at Garside.

A member of the public queried the suspension of the service at Pembridge, given that the CQC had in 2018 rated it as "good", outlined events to date and reported that they had been informed that the unit could no longer accept patients who had previously been sent to Pembridge to undertake control of their pain management. Pembridge had been providing a service across the wider community. James Benson acknowledged that the quality of leadership at Pembridge had been regarded as "good" and repeated his previously articulated response about the need for a full-time lead specialist palliative care consultant in order to deliver good quality care. Janet Cree added that they were closely monitoring patient take up of the current services available from other providers.

ACTION: The CCG and provider to provide further updates and for the PAC to continue to monitor developments closely. Further engagement work was planned by the CCG and CCG was to report back potential solutions within two to four weeks.

ACTION: For the issue to be considered at a further meeting of the PAC, planned for February 2020.

RESOLVED

That the Committee note the report and that issue continues to be closely monitored.

36. PARSONS GREEN WALK IN CLINIC (WiC)- UPDATE

Janet Cree clarified that the CCG had not taken a decision to close Parsons Green WiC but had requested an extension from NHS England to keep the WiC open so that the existing service would remain. Further information was

contained in a letter on the CCG's website. At the present time there were no plans to change the WiC.

Councillor Richardson enquired what had led to the confusion, a reprieve had been sought, then refused and then reprieved supposedly again following a Parliamentary announcement from Matt Hancock, Secretary of State for Health. Janet Cree responded that NHS guidance had set out that a change was required in December 2019 which was reported to the Committee. The CCG had been in dialogue with NSH England during this time.

Jim Grealy pointed out that the initial directive to close had come from NHS England but that the CCG statement indicated that Parsons Green would not continue. He asked if it was necessary now to rename Parsons Green since it cannot be called a "WiC" and that it would have to put in place a bookable appointment system. There was a difference between a WiC, and urgent need and it would be helpful to understand this. Janet Cree responded that several GP surgeries offered WiC appointments and wound care and was of a similar model. The CCG planned to utilise workforce and capacity within the existing system which was not being used optimally and replace this with a mixed model of care. This could have GP and nurse appointment systems running simultaneously.

A member of the public asked about the WiC intended closure at the end of March and whether an extension was likely. Janet Cree confirmed that was the case, however, the changes did not need to be implemented by the end of March. The CCG planned to undertake continued engagement with stakeholders and although WiC provision may no longer be offered at Parsons Green, the unit may look different in future. It was confirmed that 53% of patient activity was from residents of H&F. The wider patient footprint comprised of residents from other boroughs. Councillor Coleman observed that opposition to the closure of WiC across the country indicated widespread concern. Reflecting on the parliamentary comments about Parsons Green remaining open, it was noted that the Secretary of State had confirmed that there would be no need for the WiC to change to appointment only. Councillor Coleman acknowledged that this placed the CCG in an insidious position and potentially opened the floodgates to judicial review if the CCG decided to follow the Secretary of States' policy.

Councillor Caleb-Landy asked if it was possible to establish what the financial impact would be on the budget to reconfigure the WiC. Janet Cree responded this could be checked and would depend on the specification which might comprise of both WiC and appointments. In a response to a question from Victoria Brignell Janet Cree noted that Parsons Greens was regarded as a centre of excellence for ear syringing and that the service would continue after 31 March 2020

ACTION: CCG to identify the financial impact on reconfiguring the WiC.

ACTION: For the PAC to feed into the engagement work planned by the CCG. Further information about the CCGs plans for the WiC post 31st

March 2020 to be shared given that it no longer meets the required NHSE standard for urgent treatment centres.

RESOLVED

The CCG and provider to provide further updates and for the Committee to continue to monitor developments closely.

37. CQC RATINGS / CCG OVERVIEW

The Committee received a joint presentation from Janet Cree and Vanessa Andreae. This had been prompted by a "requires improvement" CQC rating given to a local GP practice. It was noted that the practice has an action plan and that the role of the CCG was to provide support and guidance as the responsibility for improvement lay with the practice itself.

Councillor Mercy Umeh asked what the impact on residents had been. It was confirmed that most residents would be unaffected.

Jim Grealy welcomed the update and reassurance offered and the fact that 19 practices had performed well with 8 achieving a "good" rating. However, 50% of those that were not deemed good were in deprived parts of the Borough. He expressed concern about the equalities impact on residents and urged the CCG to review this as a priority. It was acknowledged that practices were private businesses and that if a practice was rated as inadequate, he asked what monitoring procedures were in place, and, what was the monitoring process was to review matters before this stage. Vanessa Andreae noted that there was an impact on patients but observed that patients were also very loyal to their practices. CQC inspection regimes had evolved over the years and had become more policy and procedure based, monitored by the GP Federation. If a practice had not reviewed its polcies then it was likely to be challenged. Janet Cree added that the newly established Primary Care Networks (PCNs) were perceived as part of the solution and that changes implemented across a PCN enhanced provision. Vanessa Andreae highlighted, as an example, the low take up of immunisations which could result in a "requires improvement" rating. This had been an issue in H&F. In another example, a local GP practice had received a national award on their work to improve the number of women undergoing cervical screening. It was noted that there was a need for more proactive collaborative work and the Committee indicated that it would welcome innovative opportunities for the Council to assist the CCG in for example, advertising health information and guidance for residents regarding flu prevention on the Council website.

ACTION: Council to assist the CCG in for example, advertising health information and guidance for residents regarding flu prevention on the Council website

With reference to a point about inequalities Janet Cree commented that the PCNs were part of the solution around supporting practices and offered peer

support, particularly where there were concerns about workforce retention. It was confirmed that there was regular monitoring of individual practices and that a practice would receive two weeks' notice of a CQC visit. The GP Federation was allocated resilience funding to offer support prior to a practice CQC inspection.

RESOLVED

That the Committee considered and noted the report.

38. PRIMARY CARE NETWORKS, INTERIM CCG CLUSTERS AND INTEGRATED CARE SYSTEM STRUCTURES

Mark Easton provided a brief update on numerous changes to the CCG operating model. Engagement had commenced about the move towards a single CCG. The CCGs had begun to explore what would happen within the transitional year and to develop an understanding of what happened at both CCG and borough levels. This had led to some engagement work prior to December 2019 and there were proposals in train to cluster management teams. It was clarified that this was not about having four clusters that would exist as autonomous structures. The intention was to have 8 CCGs with 8 managing directors and to maintain some shared functions with 20% of staff working between boroughs and 80% working locally.

Councillor Coleman commented that the move towards clusters presupposed a merger which was yet to be agreed and that the criteria and conditions for the merger had not been made known. Councillor Coleman requested that the NWL Collaborative CCGs provided information about what conditions would have to be met for a merger to proceed. He also requested that the Committee be provided with the details of the work plans identified in paragraph 1.3 of the report. He continued that he had been surprised by a letter consulting CCG staff about prospective cluster arrangements without having discussed these arrangements with the Council. It had been reported that H&F would be clustered with Ealing and Hounslow, but this was not the case. H&F CCG was to be potentially clustered with Central and West London CCGs, an unwanted arrangement that reflected a historic local government arrangement between the three boroughs and which no longer existed. Councillor Coleman also sought clarification about the financial and administrative needs of GP at Hand and how this would be met by the NWL Collaborative.

In response Mark Easton referred to agreement reached between the 8 CCGs to merge in principle. In a caveat to this, there remained several issues that members of the governing bodies requested further information about. Broadly speaking these were encapsulated by five bullet points contained at page 13 of the Agenda. A more detailed paper had been submitted to the Joint Committee (of the NWL Collaborative) and covered the areas which the governing bodies said that they wanted to be satisfied about before they recommended that their members should vote in favour of a merger. Currently, the Collaborative was developing the answers to the questions posed by the governing bodies. It was confirmed that this would be shared

with the Committee when it was finalised. The document was essentially a derivative of the document produced in December 2019 and was currently in development. It was anticipated that this would be ready over the course of the next week. It was hoped that a further consultation document would be published for staff but that the priority would be to work out arrangements for the interim year before worked commenced on the longer-term changes. In response to a question about when this might be made available it was explained that this currently being worked on and that it would be shared when it was fit for public consumption and at the earliest opportunity. This would be a question of weeks as it would need to be ready before it was presented to the governing bodies in June 2020.

Responding to Councillor Coleman's earlier point regarding consultation about cluster arrangements Mark Easton contended that the Council had been consulted by describing and making known the potential options available. The chief executive officers of each Council had been informed by letter. Councillor Coleman expressed his fundamental disagreement that this qualified as 'consultation' and that this had not been discussed with the Council. Mark Easton asserted that his view was different. The clusters would share 20% of the costs arising from the shared functions referred to earlier. The groupings would not form the basis of integrated care and were subject to on-going discussions. This was an emergent point in development, and he explained that the CCGs were aware that WCC regarded the potential cluster arrangement as being 'bi-borough'. It was confirmed that the administrative cost of GP at Hand would be broadly shared. It was acknowledged that this was a huge financial burden for H&F CCG, but that this was expected to reduce. Prompted by a request for further details about the shared functions and what these were Mark Easton felt it was not appropriate to share the details in advance of sharing this with CCG staff.

ACTION: To receive a briefing about the conditions required to be met in order to for the CCGs to move forward with plans to merge.

ACTION: For the NWL Collaborative to share work plans once finalised.

RESOLVED

That the Committee considered and noted the report.

39. HEALTHWATCH UPDATE

Councillor Richardson welcomed from Healthwatch Olivia Clymer and Eva Psychrani who presented their recently published report "Healthcare in the Digital Era an Exploration of young people's health needs and aspirations in Hammersmith & Fulham". The report explored the impact of digitisation on young people nationally and a consultation link was included in the pack inviting comments from the public and stakeholders. Key findings in the report which had engaged with young people in H&F included the use of technology was not necessarily linked to health, concerns about finding the right information online and that young people were more comfortable with accessing the NHS online using log in credentials. There was also an

emphasis on maintaining a digital approach that did not infer that traditional face to face access should be 'lost'. The report had received a positive response and would ensure that NWL CCGs engagement plans around digitisation was communicated clearly to residents to help alleviate patient difficulties in accessing services. Reference was made to the previous point about with 48% of people using specialist palliative care services implying an issue around signposting which might be replicated in technology. This was an opportunity to develop an approach early on.

Councillor Richardson observed that the Council's approach to addressing mental health focused on prevention. Jo Baty confirmed that this was an issue that was being covered at Health and Wellbeing Board. Prevention was a big area of work and the findings of the report were welcomed.

Co-optee Roy Margolis welcomed the report and its interesting recommendations and asked if more detail was available about the recommendations, specifically, if any work had been undertaken on the cost of implementing them. Olivia Clymer responded that the role of Healthwatch was to identify issues, provide challenge and affect change so that the patient voice was heard and acknowledged. There were further details in the main report, and which could be included in an appendix to the report. Keith Mallinson, as Chair of the Healthwatch Central West London Committee reported that he had recently attended a CAB (Citizens Advice Bureau) forum presentation and was shocked at how many people were being signposted to services which were no longer accessible.

Jim Grealy asked how many young people consulted a GP in person and if there was a sense of whether having a digital approach was preferred in place of attending an appointment at a GP surgery. Eva Psychrani explained that there was a sense that follow up and prevention work could be digitised but that everyone needed the confidence and reassurance that arose from a face to face appointment.

It was noted that this was a valuable report given the number of people who were being turned away from CAMHs (Children and Adolescent Mental Health Services). Councillor Lloyd-Harris observed that it was helpful to have a definition of mental health which normalised the issue. The perception for example that drugs, and alcohol issues were 'normal' and therefore not perceived to be a problem by the current generation. Eva Psychrani responded that in some ways mental health concerns had been normalised and reported that the focus group had been aware of the effects of smoking and alcohol. It was clarified that the recommendation for a mental health app was not linked to having a mental health digital intervention. Mental health needs had been identified through first exploring the issue in conversation with young people and then linked to digital intervention.

RESOLVED

At 9.50pm the Committee agreed that the meeting be extended to 10.15pm.

Jo Baty confirmed that the Council would welcome the opportunity to work with Healthwatch in reviewing mental health services and acknowledged that transitioning from Children's Services to adult services could be a tricky time. Young people were not always aware that they might have a mental health issue which might have been missed earlier. It was recognised that information and guidance could always be improved.

A member of the public enquired about what support was in place for H&F residents who lived on the Edward Woods estate and had been affected by the Grenfell Tower fire. Councillor Coleman responded that the Council had reassured residents who were concerned about losing their homes and had committed £20 million to implementing fire safety measures which included the installation of fire safety doors regardless of whether residents were tenants or private owners. Lisa Redfern reported that a great deal of work had been undertaken to support residents since Grenfell in practical terms with a variety of Council services being offered.

ACTION: For the Strategic Director to identify what support had been put in place for H&F residents on the Edward Woods estate following the Grenfell Tower fire.

Councillor Coleman observed that the report interesting and that the Council had been working with the Youth Council to develop an app on information about available activities within the borough. This dovetailed with the work on social isolation and loneliness which also addressed mental health. Councillor Coleman also observed that there was a clear contrast highlighted between young people accessing services and young professionals accessing GP at Hand.

RESOLVED

That the Committee welcomed and noted the report.

40. 2020/2021 MEDIUM TERM FINANCIAL STRATEGY (MTFS) - ADULT SOCIAL CARE AND PUBLIC HEALTH

Lisa Redfern led a presentation that informed the Committee of planned departmental financial spending for the forthcoming year and the intention to deliver again a balanced budget. Key achievements included free home care, subsidised meals on wheels, the commencement of a podiatry service and ensuring that all contractors paid staff the minimum living wage. Two in-house services had been rated as outstanding and improvements to other services had received positive feedback from residents. A safeguarding peer review by the Association of Directors of Social Services had achieved an outstanding result. Delayed transfer of care figures had now placed the borough as the third lowest in London and a quality assurance framework had just been launched. These were all achieved under challenging circumstances with increased demand, greater acuity of need, and complexity of care within an ever-reducing budget.

Councillor Lloyd-Harris enquired about the current level of the Council's reserves. Hitesh Jolapara responded that the reserve figure needed to be considered in the context of ten years of austerity. H&F was average in London in terms of the level of reserves which was currently retained at £90 million. The Corporate budget would contribute a further £7.2 million to reserves which included income received through business rates. The Council's intention was to continue to be ruthlessly financially efficient.

RESOLVED

That the Committee noted the report.

41. WORK PROGRAMME

RESOLVED

That the Committee noted the report.

42. DATES OF FUTURE MEETINGS

Tuesday, 24 March 2020.

Meeting started: 7pm
Meeting ended: 10.15pm

Chair .....

Contact officer: Bathsheba Mall
Committee Co-ordinator
Governance and Scrutiny
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Health, Inclusion and Social Care PAC Actions/recommendations log 2019/20

Date of Meeting	Minute Ref.	Agenda Item	Notes	Lead Organisation	Status / resolution
17-Jun-19	14	Update From the Strategic Director of Social Care	**ACTION:** Victoria Brignell enquired about annual surveys and whether the data and results were published. LR to provide ASCOF information when finalised.	LBHF - Strategic Director of Social Care	On-going
			ACTION: Strategic Director to send information aout short breaks and support for carers to Cllr Caleb-Landy; and to confirm for members details of Lunch and Learn sessions**.**	LBHF - Strategic Director of Social Care	Completed - 5 August 2019. Update prepared by Commissioning Strategic Lead and provided to Cllr Caleb-Landy.
11-Sep-19	22	Actions and Matters Arising	**ACTION:** Collaborative CCGs to provide the Committee with a timetable of key consultation dates, following the postponement of the vote by the CCG governing bodies to merge.	Collaborative CCGs	On going. Report to the PAC 27 January 2020.
	25	Primary Care Networks	**ACTION:** Draft CCG response to the NHS Long Term Plan document to be shared with the Council at the earliest opportunity.	Collaborative CCGs	Completed - September 2019
	26	NHS Long Term Plan Update	**ACTION:** CCG (Juliet Brown) to contact LR to arrange meeting to discuss draft response to LTP.	Collaborative CCGs	Completed - November 2019
	27	Healthwatch Update	No actions from this meeting.	_	_
	28	Pembridge Hospice / palliative care	CCG to keep the Committee updated.	CCG	On-going
	29	Work Programme	CCG to provide more detailed information about this.	CCG	Report to the PAC 27 January 2020

27-Jan-20	35	Palliative Care	The CCG and provider to provide further updates and for the PAC to continue to monitor developments closely. Futher engagement work was planned by the CCG. **ACTION:** CCG to report back potential solutions within two to three weeks.	CCG	Report considered on 12 December 2018; September 2019 and January 2020. On-going. CCG pulbished Invovlement document,
			ACTION: For the issue to be considered at a further meeting of the PAC, planned for February 2020.	LBHF / CCG	On-going.
	36	Parsons Green WiC	The CCG and provider to provide further updates and for the PAC to continue to monitor developments closely. **ACTION:** For the PAC to feed into the engagement work planned by the CCG. Further information about the CCGs plans for the WiC post 31st March 2020 to be shared given that it no longer meets the required NHSE standard for urgent treatment centres.	CCG	Report considered on 11 September 2019 and 27 January 2020. On-going
			ACTION: CCG to identify the financial impact on reconfiguring the WiC.	CGG	On-going.
	37	CQC Ratings	**ACTION:** CCG to further consider ways in which the Council can assist and support the dissemination of health advice either through Public Health or utilising the Council's existing Communications network.	CCG / LBHF	Completed - 24 February 2020. LBHF created a helpful box/link on the external website with links to PHE info (a live website that is continually updated).
	38	Primary Care networks, Interim CCG Clusters and Integrated Care System Structures	**ACTION:** To receive a briefing about the conditions required to be met in order to for the CCGs to move forward with plans to merge.	NWL CCG Collaborative	Completed - 25 February 2020. Consultation document emailed to HISPAC, Cabinet Member and officers.
			ACTION: For the NWL Collaborative to share work plans once finalised.	NWL CCG Collaborative	On-going.

	39	Healthwatch Update	**ACTION:** For the Strategic Director of Social Care to provide an update on the number of people supported by the Council in accessing mental health services post Grenfell.	LBHF	On-going.

London Borough of Hammersmith & Fulham

Report to: Health, Inclusion and Social Care Policy & Accountability Committee

Date: 4 March 2020

Subject: Specialist Palliative Care Services

Report of: Hammersmith & Fulham Clinical Commissioning Group

Responsible Director: External Report from Janet Cree, Managing Director, Hammersmith & Fulham Clinical Commissioning Group

Summary

This report provides an update on the future provision of local specialist palliative care services.

Recommendations

That that the Committee considers, comment on and note the report.

Wards Affected: All

Contact Officer:

Name: Janet Cree
Position: Managing Director, Hammersmith and Fulham Clinical Commissioning Group
Telephone: 0203 350 4273
E-mail: janet.cree@nhs.net

Background Papers Used in Preparing This Report

None.

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1. Introduction

1.1 This report provides an update to the Committee on the work that is being undertaken across four of the eight NW London CCGs on specialist palliative care.

2. Background

2.1 The CCG presented a paper to the Committee in September 2019 and January 2020 setting out an updates on the work that was being done to consider the Strategic Review of Palliative Care that was undertaken by an independent reviewer. The review provided a comprehensive assessment of the current local service

provision, a review of best practice and made a number of recommendations for commissioners to consider for the future model of service. The review identified a number of challenges across the services in the areas of:

- inequity of specialist palliative care services in the three boroughs
- inequity of access to the services, with only 48% of people who have an expected death having any contact with community palliative care services;
- 70% of patients would prefer to die in their own home but are unable to; and
- inequity of funding arrangements for the services from the CCGs.

The full report can be found here https://www.centrallondonccg.nhs.uk/news-publications/news/2019/06/strategic-review-of-palliative-care-services.aspx

Janet Cree
Managing Director
Hammersmith and Fulham Clinical Commissioning Group
February 2020

List of Appendices:

Item 5.1 Palliative Care Services Involvement Document February 2020
Item 5.2 Palliative Care Services Stakeholder Letter February 2020

Palliative care services

Re-designing services for people with an incurable illness or in their last phase of life in Brent, Hammersmith & Fulham, Kensington & Chelsea and Westminster

Your feedback on potential scenarios

Thank you if you have been involved in the process so far and for your patience. We are confident that by continuing to work together with local patients, carers and partners we have an opportunity to improve palliative care services across the four boroughs.

What this document is for

The local NHS is reviewing specialist palliative care services across Brent, Kensington & Chelsea, Hammersmith & Fulham and Westminster.

This document sets out our current thinking about how we may organise specialist palliative care services in future. It is intended to provide a background to our current situation and form a basis for further discussion.

We want to involve our patients and local people in agreeing the way forward, so we have produced this document as a way of discussing potential scenarios for improving specialist palliative care.

This is not a consultation document. At this stage we want to open up a discussion which we hope you will want to take part in.

Contents

Accessibility

We want as many people as possible to tell us their views, if you need this information in a different format like a printed or large print copy, easy read, audio recording or a translated version, please let us know what you require and we'd be happy to help.

- Email the project inbox at nwlccgs.triborough.palliativecare@nhs.net
- Call our office to speak to us to discuss on 0203 350 4366.

What do we mean by palliative care services?

- **Palliative care** is support for people living with an illness which isn't curable and aims to improve a patient's quality of life. Examples of these illnesses include advanced cancer, motor neurone disease (MND) and dementia. You can receive palliative care at any stage in your illness. Having palliative care doesn't necessarily mean that you're likely to die soon – some people receive palliative care for years.
- Palliative care also includes care of people who are in the last months or years of their life, known as '**end of life'.** End of life care aims to help people to live as comfortably as possible in their time left. It involves managing physical symptoms and getting emotional support for the patient, their family and friends.
- Palliative care takes into consideration a patient's physical, emotional, psychological, social and spiritual needs. This is called a holistic approach, because it deals with people as a "whole" person, not just your illness or symptoms.

What is the difference between general and specialist services?

- **Palliative care** is often delivered at a person's home (including care or nursing home) by local **'general' services** such as your GP, community and district nursing teams.
- Depending on a person's condition, needs and preference **'specialist care'** may also be required. This is often provided by hospice services and staff. Hospice care is a style of care, rather than something that takes place in a specific building. It can be delivered at home by community nursing teams or through in-patient or day care services.
- Specialist palliative care teams are made up of many different healthcare professionals who co-ordinate care for an individual. This may include consultants, specialist nurses, occupational therapists or physiotherapists trained in palliative medicine.
- As specialists, they also advise other professionals on palliative care such as GPs and community nurses.
- For more information on these terms specialist palliative care and other terms we may reference in this document please see the accompanying information pack or visit nhs.org.uk.

Doesn't everyone need specialist services?

- Not everyone will need specialist palliative care and will be managed by their 'local general' team. Some people dependant on their situation and the complexity of their needs and circumstance will do and this would be classed as 'specialist palliative care'.
- People also have the right to express their wishes about where they would like to receive care and where they would like to die.

This review focusses on specialist palliative care services (often provided by hospices) in these areas, the aim however is that any proposed changes to specialist care supports improvements in 'general' care, as described above, so that everyone has access to the right care when they need it.

Why do we need change?

Inpatient care within our local hospices resoundingly provides high quality and expert care to those patients with the most complex medical needs. Patients, families and carers who have used inpatient care rate this care as excellent and it is clear that all of our local providers of specialist palliative care are well-loved and respected by the communities they serve.

We are now bringing together the findings from the independent review (available on our website) undertaken earlier this year with the views of patients, the public and professionals working in providing palliative care. The most consistent feedback from professionals and the public however is about the inconsistency in services provided to people in different areas, and the difficulty for some people in accessing these services. Poor co-ordination and communication between services is also a key theme, as well as timeliness and the lack of emergency response when most needed.

The independent review also highlighted that our current inpatient services may not be appropriately sized for the needs of our population and that it's important that we invest in a mix of services to ensure improved consistency and better meet people's preferences, in their last phase of life.

What challenges are we trying to address?

Access to services - only 48% of people with a palliative care need are accessing services when they need them. Reaching only 48% of patients is not good enough. It is paramount that we increase the reach of palliative care services to all patients who need it, regardless of their condition.

Inconsistency between services – depending on where you live you will have more or less access to specialist palliative care services and this is not acceptable. For example, while some hospices can support people to die at home if they wish, others do not. There is also variation in what services can be accessed out of hours and how quickly, for example in the middle of the night or at the weekends.

Underinvestment in community services contributes to differences in what services are available for people to access. Our vision is that everyone gets the palliative care that they need. We aim to increase this number up to a **minimum** of **75% initially**. Investing in community services will enable us to reach more people in their last phase of life.

A lack of co-ordination between services can result in care being delayed or interrupted which causes anxiety and stress for patients, carers and families and unnecessary discomfort to the patient.

National staff shortages in palliative care specialists - this has been a challenge locally and due to a specialist palliative consultant not being available led to the suspension of the in-patient unit at the Pembridge palliative care centre, highlighting the fragility of our local system.

Timeline of the process so far

So far:

- **October 2018:** A decision to temporarily suspend the Pembridge Palliative Care Inpatient Unit was made by Central London Community Health NHS Trust and Central London CCG due to the inadequate medical cover
- **December 2018:** Call for evidence launched for the Independent Review. The review held interviews with over 50 health and care professionals and received 101 responses to a public survey from the public, staff and patient groups.
- **June 2019:** Palliative care services Independent Review published
- **September - October 2019:** 3 public engagement workshops held in Brent, Hammersmith and Kensington. The purpose of these workshops were to involve the public in any future model of palliative care services

Next steps:

- **February – March 2020:** Engagement period where the public can feedback on the CCGs potential solutions
- **March 2020**: Outcomes of the engagement period will be presented to CCG governing bodies for consideration of the next steps
- **May 2020:** Potential Consultation period – should any recommendations be classed as a 'substantial' change to the existing palliative care service by our governing bodies (the CCG boards) and associated NHS bodies these changes will be subject to a public consultation

What we have heard so far

Since December 2018 we have engaged; local patients, families, carers, residents, the voluntary and community sector, and patient representative groups across the four boroughs. Initially we launched a 'Call for evidence' to hear from local people and professionals about their views on services and how they are working. This information formed the basis of an Independent review. Between September and October 2019 three well attended public workshops were held to look at people's experience of palliative care services from end to end; focussing on access, care and the transfer of care and bereavement.

Key themes

There is also a findings report of key themes – this can be accessed **here**.

Summary of themes from the workshops:	
	Care works well once a service or pathway has been accessed with inpatient hospice services offering peace of mind for family, friends and carers. However many people aren't in contact with any services at all
	Care is not standardised across different areas in the four boroughs
	Access to information and support to help navigate available services is inconsistent
	Care planning should be transparent with family, friends and carers and start at an earlier stage
	More could be done to ensure that minority groups are aware of palliative care services and ensuring that these services are personalised for a diverse range of communities
	Travel times to hospice services have a significant impact on carers and families. This should be a focus for any future model of care
	More could be done to improve integration and coordination between services
	Bereavement services need to be in place at the right time and be promoted better to friends, family and carers

Feedback from our engagement: below is a summary which details how we are listening to your feedback and improving patient & public involvement in the process.

You said	***You would like more information about the consultation process***
We did	We have provided the above timeline of the review process so far and the next steps for the process. We are not in consultation now but if significant change is proposed to these services then we consult the public which would happen later this year.

You said	***You would like an opportunity to discuss the future of the Pembridge Palliative Care Centre***
We did	In the survey below also available online we would like to hear your thoughts and feedback on the 4 proposed scenarios. Please use this opportunity to voice any concerns you have around the suspension of the Pembridge Palliative Care centre.

You said	***You would like to be more involved in developing future scenarios for palliative care services***
We did	We advertised for patients and the public to join a Patient and Public Palliative Care Working Group to ensure local people have a voice. We are working together with this group to discuss possible scenarios which we are now sharing with you in this document.

You said	***You would like more information about palliative care to help you make an informed decision about the future of these services***
We did	We have produced an **information pack** to support this document that has a glossary of the different aspects of the palliative care review. If you require more information around a certain topic please let us know through the contact details at the bottom of this document.

You said	***You would like to be more involved in the process***
We did	We are committed to involving residents and patients throughout this process as much as possible. We gathered people's feedback as part of the independent review and in Autumn 2019, we ran a series of workshops on how we can improve palliative care services. From this feedback and through working with our Patient and Public Palliative Care Working Group, we have now developed some potential scenarios, outlined in this document that we would like to hear your feedback on. You can also sign up for the latest updates and we will add you to our mailing list.

Current services

Here is a description of the different elements of specialist palliative care services:

- **Community services**
  You may not need to move away from home to receive care, community nurses can come to your home at any stage in your condition and provide nursing care for you there.
- **Inpatient services**
  This is care of patients whose condition requires an admission to a hospice or hospital bed.
- **Day services**
  Services and activities that can be accessed during the day including clinical, financial, emotional and spiritual support when an admission is not needed.
- **Hospice@Home**
  You may need more specialist care from community palliative care nurses who visit you at home, this tends to be in the last phase of life and therefore may be more intensive.
- **Out of hours**
  This is the period from when the day and community services close until the following morning.

An overview of what is currently being commissioned across these four boroughs by each of the main specialist palliative care services:

	Inpatient unit (IPU)	Community visiting service	Day service opening hours	Hospice@home	Out of hours (after 5pm)
Marie Curie: **11 Lyndhurst Gardens, Hampstead, London NW3 5NHS**	*26 beds 24/7 admissions available*	*Not provided to 4 boroughs*	*5 days a week service 9-5pm Mon – Fri No weekend services*	*Not provided to 4 boroughs, except Marie Curie Night Nursing Service available.*	*24/7 clinical advice line available Mon – Sun.* *No visiting service.*
Pembridge Palliative Care Centre Services: **St Charles Centre for Health & Wellbeing, Exmoor St Ladbroke**	*13 beds 24/7 admissions available* ****currently Suspended due to no consultant cover – all other services***	*7 days a week 8:30 -5pm Mon- Fri 9 – 5pm Weekends & Bank holidays*	*4 days a week service, 8.30am – 4pm No weekend services*	*Not provided to 4 boroughs.* *(accessed via other providers)*	*24/7 clinical advice line available Mon – Sun.* *No visiting service.*

Grove, London W10 6DZ	***operating as usual from this location****				
Royal Trinity Hospice: **30 Clapham Common North Side, Clapham Town, SW4 0RN**	*28 beds 24/7 admissions available*	*7 days a week 9-5pm Mon – Sun (including bank holidays)*	*5 days a week service, 9-5pm No weekend services*	*Not provided to 4 boroughs.* *(accessed via other providers)*	*24/7 clinical advice line available Mon – Sun.* *No visiting service.*
St John's Hospice: **60 Grove End Rd, St John's Wood, London, NW8 9NH**	*18 beds 24/7 admissions available*	*7 days a week 9-5pm Mon - Sun*	*4 days a week service. 8.30 – 5pm No weekend service*	*Service is provided to Westminster, Kensington and Chelsea and south Brent residents.*	*24/7 clinical advice line available Mon – Sun.* *No visiting service.*
St Luke's Hospice: **Kenton Grange, Kenton Rd, Harrow HA30YG**	*12 beds 24/7 admissions not <u>available.</u>* *Admissions are available Mon – Fri, 9am – 4pm. and only if planned for weekends.*	*5 days a week 9-5pm Mon– Fri (7 day a week service April 2020)*	*5 days a week service, 9 – 4:00pm No weekend service*	*Service is provided to north Brent resides.*	*24/7 clinical advice line NOT available.* *Advice available Mon – Fri 9am – 5pm.* *No out of hours or weekend cover.* *No visiting service*

Potential scenarios

Working with our local hospice providers in the area and from the information we have gathered from our working group and the local community around specialist palliative care services, we have proposed some potential scenarios that we would like to hear your views on. These potential scenarios aim to address the challenges we face which are:

- Current services are only reaching half of people with palliative care needs
- Services offered across the four boroughs are inconsistent
- There is an underinvestment in our community services which means we may not be able to meet people's preferences in their last phase of life
- A lack of co-ordination between services and support out of hours
- A national shortage of specialist staff to cover these services safely

Please complete the feedback survey at the end of this document or our online survey here.

Potential scenario 1 – services remain the same	
This scenario would keep all specialist palliative care services as they are including the re-opening of the inpatient unit at the Pembridge, subject to the appointment of a palliative care consultant. In-patient, day and community care services would continue as they are.	
Benefits	***Disadvantages***
• *No change to the location of any services.*	• *Services won't increase the number of patients that they see, currently services only have the capacity to support around half of patients with a palliative care need.*
• *This would mean re-opening the in-patient unit at the Pembridge Palliative Care Centre.*	• *Improvements needed raised by patients and staff regarding communication and coordination of services will be addressed but limited.*
• *No increase in travel for specialist in-patient services.*	• *Services will not be in line with national guidance.*
	• *Access to day services will remain inconsistent.*
	• *Access to community services will remain inconsistent.*
	• *'Out of Hours' service will remain inconsistent.*
	• *Hospice@Home not available to all.*
	• *No guarantee of when it will be possible to recruit a specialist palliative care consultant into this post.*

Potential scenario 2 – Some improvements to day and community services with in-patient services remaining the same	
This scenario would keep in-patient services as they are now, including the re-opening of the inpatient unit at the Pembridge palliative care centre subject to the appointment of a palliative care consultant. Community and day services would be standardised across the boroughs. *This scenario would lead to some but limited improvements in the co-ordination of out of hours advice.*	
Benefits	***Disadvantages***
• *Community services would be open consistently 7 days a week.*	• *Services won't increase the number of patients that they see significantly, currently services only have the capacity to support around half of patients with a palliative care need.*
• *Day care services would increase from 4 to 5 days a week with consistent opening hours.*	• *Access to community services will remain inconsistent.*
• *Some, limited improvements to out of hours services.*	• *Improvements needed raised by patients and staff regarding communication and coordination of services will be addressed but limited.*
• *This would mean re-opening the in-patient unit at the Pembridge Palliative Care Centre.*	• *Services will not be in line with national guidance.*
• *No increased travel for specialist in-patient services.*	• *'Out of Hours' service will remain inconsistent.*
• *No change to the location of inpatient or day care services.*	• *Hospice@Home not available to all.*
• *Improved co-ordination of services with providers working together.*	• *No guarantee of when it will be possible to recruit a specialist palliative care consultant into this post.*

Potential scenario 3 – A re-design of all elements of specialist palliative care services	
This scenario would see in-patient services delivered from four rather than five hospices but without reducing the number of beds that the NHS funds. *This would enable CCGs to fund community services 7 days a week, with 24/7 admissions for patients, consistent day care and out-of-hours services, and Hospice@Home available to all.*	
Benefits	***Disadvantages***
• *A greater level of access and consistency of services available to all.*	• *The hospice locations where patients can access inpatient care would reduce from 5 to 4.*
• *A greater level of funds for community and day-care services would be available so that more people can benefit from these services and services would work better together.*	• *As a result of reducing the hospice locations where patients can access inpatient care, some patient's carers and family will have to travel further or longer to visit patients who are receiving inpatient care.*
• *Community services would be available 7 days a week and the hours would increase to 8am-8pm.*	• *The hospice location likely to close is the Pembridge in-patient unit. However this requires further consideration and has not been confirmed.*
• *There will be no reduction in NHS funded hospice beds.*	
• *Hospice@Home available to all.*	
• *Day care services would increase from 4 days to 5 days and extended to be consistent.*	
• *Increased investment will improve co-ordination of care for patients and families with 24/7 palliative care needs.*	
• *Increased investment will deliver responsive out of hours urgent and emergency palliative care, joined up with London Ambulance Service and NHS 111.*	
• *Specialist services will deliver increased training and education in palliative care for GPs, District Nurses and Care Homes and enable easier access to advice from the specialists when required.*	
• *Increased investment will deliver improved palliative care for homeless patients and other hard to reach groups, with support from outreach teams.*	

Potential scenario 4 – A re-design of all elements of specialist palliative care services including access to a new nurse-led in-patient service	
This scenario would see in-patient services delivered from four rather than five hospices but without reducing the number of beds that the NHS funds. This would enable CCGs to fund community services 7 days a week, with 24/7 admissions for patients, consistent day care and out-of-hours services, and Hospice@Home available to all. *Patients who do not require specialist inpatient care but cannot be supported at home or have a preference to die in a hospice environment, can access respite and end of life care in their local area via a nurse led in-patient service.*	
Benefits	***Disadvantages***
• *A greater level of funds for community and day-care services would be available so that more people can benefit from these services and services would work better together.*	• *Patients who require specialist consultant-led inpatient care will be affected and have to travel to an alternative hospice service.*
• *A greater level of access and consistency of services available to all.*	• *The hospice location likely to close is the Pembridge in-patient unit. However this requires further consideration and has not been confirmed.*
• *Community services would be available 7 days a week and the hours would increase to 8am-8pm.*	
• *There will be no reduction in NHS funded hospice beds.*	
• *Hospice@Home available to all.*	
• *Day care services would increase from 4 days to 5 days and extended to be consistent.*	
• *Increased investment will improve co-ordination of care for patients and families with 24/7 palliative care needs.*	
• *Patients who do not require specialist consultant-led inpatient care can access respite and end of life care in their local area via a nurse led service.*	
• *This would overcome the current issue with specialist staff shortages.*	
• *Increased investment will deliver responsive out of hours urgent and emergency palliative care, joined up with London Ambulance Service and NHS 111.*	
• *Specialist services will deliver increased training and education in palliative care for GPs, District Nurses and Care Homes and enable easier access to advice from the specialists*	

when required.	
• *Increased investment will deliver improved palliative care for homeless patients and other hard to reach groups, with support from outreach teams.*	

Thank you for reading this document

Please now complete the feedback survey at the end of this document or complete the online survey **here** and let us know what you think about these scenarios.

We are happy to consider additional potential scenarios that might help to address the challenges outlined above – please include any suggestions in your response.

What happens next?

Once we have heard your views a proposal will be put forward to CCG governing bodies for consideration of the next steps. Should they take the view that a significant change from the current service provided is required, then we would move to a public consultation which would ensure further engagement opportunities for local people to be involved in, to develop the future model of care.

Thank you for your on-going participation

Brent CCG

Central London CCG

Hammersmith & Fulham CCG

West London CCG

NHS
North West London
Collaboration of
Clinical Commissioning Groups

Survey

Complete online, return FREEPOST - NW LONDON
or email nwlccgs.triborough.palliativecare@nhs.net

Now you've read our aims and possible scenarios for the future, we want to know what you think. **This is not a consultation,** but an engagement period to get your thoughts to help shape the future design of these services. These scenarios are based on the challenges outlined above and what will reach the most amount of people across these boroughs.

Section 1 – Should we change our services

Have you or a family member or friend used the following services in Westminster, Hammersmith & Fulham, Kensington & Chelsea or Brent? *(Please circle as appropriate)*

Yes / No

Which of the following services did you use?

- General local palliative care services - *Yes / No*
- Specialist palliative care (often provided by a hospice) - *Yes / No*
- End of life care (often provided by a hospice) - *Yes / No*
- Unsure - *Yes / No*

If yes to any of the above, please tell us the name of this service.

Do you agree that we need to help more people to access palliative care services and to make what is available more consistent for everyone? *(Please circle as appropriate)*

Yes / No

Please rank the importance of the following aspects of palliative care for you? *(Definitions available on page*

(1 = most important, 6=least important)

Community Care	
Out of hours care and support	
Access to specialist advice	
Services delivered at home	
Day centre services	
In-patient services	

What is the most important thing that palliative care services offer to those that need them?

Section 2 – your views on each scenario

Potential scenario 1

Services remain the same

This scenario would keep all palliative care services as they are including the re-opening of the inpatient unit at the Pembridge, subject to the appointment of a palliative care consultant. In-patient, day and community care services would continue as they are.

Comments:

Concerns:

Suggestions to improve the scenario:

Potential scenario 2

Some improvements to day and community services with in-patient services remaining the same.

This scenario would keep in-patient services as they are now, including the re-opening of the inpatient unit at the Pembridge subject to the appointment of a palliative care consultant. Community services would also be standardised to 5 days week.

This scenario would also lead to some improvements in the co-ordination of out of hours advice.

Comments:

Concerns:

Suggestions to improve the scenario:

Potential scenario 3

A re-design of all elements of palliative care services

This scenario would see in-patient services delivered from four rather than five hospices but without reducing the number of beds that the NHS funds.

This would enable CCGs to fund enhanced community services 7 days a week, with 24/7 admissions for patients. It would also provide an out-of-hours nurse visiting service and Hospice@Home available to all.

Comments:

Concerns:

Suggestions to improve the scenario:

Potential scenario 4

A re-design of all elements of palliative care services including access to a new nurse-led in-patient service

This scenario would see in-patient services delivered from four rather than five hospices but without reducing the number of beds that the NHS funds. CCGs would then fund enhanced community services.

Patients who do not have complex medical needs, but whose preference is to die in a hospice environment could receive care by a nurse-led service at a bed in North Kensington provided by the Pembridge Palliative Care Centre.

Comments:

Concerns:

Suggestions to improve the scenario:

Section 3 – your preferred scenario

What is your preferred potential scenario? (Please circle as appropriate)

1	2	3	4

Please rank each scenario? (1 = most preferred scenario, 2 = preferred scenario 3 = least preferred)

Potential scenario 1	
Potential scenario 2	
Potential scenario 3	
Potential scenario 4	

Is there another scenario you would like to be considered?

Any other comments?

Section 4 – About you

Which borough do you live in?

Where is your closest hospice?

How did you hear about this survey?

How would you like us to involve you and the wider community in the future?

If you would like to join our mailing list please include your email below:

Contact - any questions call 0203 350 4366 or nwlccgs.triborough.palliativecare@nhs.net

North West London
Collaboration of
Clinical Commissioning Groups

About you

To ensure we are representing our diverse community, we would be grateful if you could complete the below questions - the details you provide are strictly confidential. It's a legal requirement for us to ask these questions, but you are not obliged to answer any you do not wish to.

Gender (please circle):

Man / Woman / Non-binary / Prefer not to say
If you prefer to use your own term, please specify here:

Is your gender identity the same as the gender you were originally assigned at birth (please circle as appropriate):

Yes / No / Prefer not to say

Age group (please put an x in the correct box):

Under 18	18 - 24	25 – 34	35 – 44	45 – 54	55 – 64	65 – 74	75 or over	Prefer not to say

Which of the following best describes your sexual orientation (please put an x in the correct box):

Heterosexual/straight	Lesbian/Gay Women	Gay Man	Bisexual	Prefer not to say

If you prefer to use your own term, please specify here:

……

Which of the following best describes your religion or belief (please put an x in the correct box):

No religion	Buddhist	Christian	Hindu	Jewish	Muslim	Sikh	Prefer not to say

Other (please state)

……

How would you describe yourself?
Using the following classifications, how would you describe your ethnic origin (please tick appropriate box).

White		**Black or Black British**	
White British		Caribbean	
Irish		African	
Gypsy/Irish traveller		Other Black background	
Polish		All Black groups	
Other white background			
All white groups			
Mixed		**Other**	
White and Black Caribbean		Somali	
White and Black African		Irish traveller	
White and Asian		Romany	
Other mixed background		Arab	
		Other ethnic group (please describe below)	
Asian or Asian British		Prefer not to say	
Indian			
Pakistani			
Bangladeshi			
Other Asian background			
All Asian groups			

Do you consider yourself to have a disability/impairment?

Yes ☐ No ☐

Contact us

- Email this back to our inbox at nwlccgs.triborough.palliativecare@nhs.net
- Post your survey back to us at FREE POST: HEALTHIER NW LONDON.
- Any problems call us on 0203 350 4366.

North West London
Collaboration of
Clinical Commissioning Groups

North West London Clinical Commissioning Groups
15 Marylebone Road
London
NW1 5JD

14 February 2020

Dear colleague,

Re: review of specialist palliative care services in Brent, Kensington and Chelsea, Hammersmith and Fulham and Westminster

Following previous communications, we are writing to update you on the next steps of the review of palliative care services taking place across Brent, Kensington and Chelsea, Hammersmith and Fulham and Westminster.

As commissioners and providers we are in agreement that reaching only 48% of patients who may have a palliative care need is not good enough. It is paramount that we increase the reach of palliative care services to all patients who need it, regardless of their disease type.

This is an opportunity to re-design our services to make sure they reach more people, are better co-ordinated and are more responsive in an emergency - no matter the time of day. Together these improvements will ensure that patients and their families have a better experience of care, whether managing an incurable condition or in their last phase of life.

Future potential scenarios
Working with our local hospice providers in the area and from the information we have gathered from our 'patient and public working group' and our local communities, we are proposing a number of potential scenarios that we would like to hear your views on as we progress to a future model of care.

On our website we have published an **'Involvement Document'** which outlines the background to the review, the challenges we are looking to address, and a survey for local communities and stakeholders to feed back their views to us and inform the next stage of this work.

In the next month we will be sharing this document and survey as widely as possible. We will also be meeting a number of groups in the area, who have been identified in our equalities impact screening assessment, to be potentially impacted by a re-design in how these services are delivered.

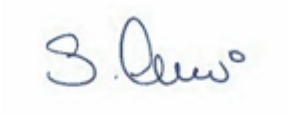
Your views
Please visit our website and circulate this information to any relevant groups who may wish to take part in this process. We would like as many people as possible to tell us their views. If this information is required in a different format please let us know what you require and we would be happy to help.

The Pembridge palliative care centre in-patient unit
Unfortunately, the in-patient unit at the Pembridge Palliative Care centre will remain suspended at this time, with the community and day care services continuing to operate as normal. Alternative provision will remain in place during this period.

We are keen to progress this to a successful resolution as soon as possible and look forward to engaging with you in support of this.

Any further questions or to discuss this matter further, please contact us at nwlccgs.triborough.palliativecare@nhs.net.

Yours sincerely,



Sheik Auladih
Managing Director
Brent CCG

Jules Martin
Managing Director
Central London CCG

Louise Proctor
Managing Director
West London CCG

Janet Cree
Managing Director
West London CCG

London Borough of Hammersmith & Fulham

Report to: Health, Inclusion and Social Care Policy & Accountability Committee

Date: Wednesday 4 March 2020

Subject: Inclusive Employment Update

Report of: Jo Baty, Assistant Director Mental Health, Learning Disability and Provided Services

Summary

To inform the Committee about progress to date on the area of improving the inclusive employment offer.

Recommendation

To note the progress to date and for members to comment.

Wards Affected: All

H&F Priorities

Our Priorities	Summary of how this report aligns to the H&F Priorities
• Building shared prosperity	To address the largest disability employment gap of all London Boroughs at over 50% compared to 28% for London
• Creating a compassionate council	
• Doing things with local residents, not to them	

Contact Officer:

Name: Jo Baty
Position: Assistant Director Mental Health, Learning Disability and Provided Services
Telephone: 07977469618
Email: jo.baty@lbhf.gov.uk

Background Papers Used in Preparing This Report

Terms of Reference Inclusive Employment Network.

List of Appendices:

Supported Employment – PowerPoint presentation

Health, Inclusion and Social Care Policy and Accountability Committee

Wednesday 4th March 2020

Inclusive Employment Update

Employment and Skills in Hammersmith & Fulham

- Overall economic indicators are fairly strong – the borough has the lowes unemployment ration in London (proportion of working age residents unemployed – 3.4%)
- Low levels of low paid residents (16% compared to London figure of 22%
- Low levels of residents employed below level 2 and high levels of residen qualified above level 4
- 210,000 new jobs are expected to be created in West London between 2016 and 2041 – many will be in Science, Technology, Engineering, Arts and Mathematics (STEAM) sectors
- In Health and Social Care, West London is the largest employer withy 500 new workers required annually just to maintain the 11% vacancy rate

However

- H&F has the largest disability employment gap of all London Boroughs at over 50% compared to 28% for London

- Out of work benefit claimants are increasing in the borough and in the last 3 years figure has moved from 2.3% to 3.6%

Summary of our work to date to address the disability employment gap:

- Children's Services 'Local Offer' website development – communicating pathways to work for young people with special educational needs and disabilities (SEND) and co-producing with parent / carers the materials to clarify those pathways.
- Collaboration over last 3 years with Parents Active to co-ordinate Focus Groups with parents / carers to review existing support into work and wider Preparing for Adulthood (PfA)
- Training and development of our local workforce around raising awareness and aspiration around employment – SENCO's; Teachers; Key Workers; Social Workers
- Co-production with young people with SEND – evaluation of Supported Internship and utilising Youth Take Over Day 2018 to further develop Local Offer website

Summary of our work to date to address the disability employment gap (continued):

- Appointment of Post 16 Pathways and Employment Co-Ordinator in SEND Service to
    a) Further develop and promote support pre and in-work
    b) To advise young people and their families as to how best to progress work aspirations post school – be it generic Employability Courses, Supported Internships; Traineeships and Apprenticeships
- Appointment of Employment Co-Ordinator in Social Care to
    a) Further develop and communicate pathways and associated support pre and whilst in employment for adults with Learning Disabilities
    b) To further communicate support available for adults with mental health issues and whilst in employment
- Established the Inclusive Employment co-production group – working with ten adults and their families and friends and support workers (as appropriate) to provide them intensive support into work
    a) To test the current support available
    b) To evidence gaps as experienced by our residents
    c) To further communicate support available for adults with mental health issues and whilst in employment

Support Internships background

- Supported internships were first developed in the US in 1996, starting in Hospitals, and ar a structured study programme for four days a week full time work experience and one day education (usually on site with the employer)
- SIs enable young people with an Education, Health and Care Plan (EHCP) aged 16 and to 24 to undertake an academic year of work experience. They undertake 3 termly rotatio in different departments with support from a work-based mentor and a trained Job Coach ensure they get maximum opportunity to secure paid work.
- Job outcomes for the 20 Supported Internships across West London Authorities over the last 2 years have been 60%
- Job outcomes for the two H&F Supported Internships:
    - LBHF / L'Oreal - young people achieving full time employment = 14 (5 LBHF residents)
    - West Middlesex Hospital / Queensmill - young people achieving full time employment = 5 (2 LBHF residents)

Supported Internships in West London

- Over 20 Supported Internships now exist across West London, which has the most developed Supported Internship in London
- Hammersmith & Fulham have hosted the annual Supported Internship Fair at West London College (Barons Court site)

- Employers hosting Supported Internships under the 'West London Alliance' include:

  - LBHF / L'Oreal
  - Glaxo-Smith Kline
  - Hilton Terminal 5
  - Great Ormond Street
  - Moorfields
  - Marriot Hotel
  - Westminster City Council
  - Royal Borough of Kensington and Chelsea
  - Hounslow Council
  - Public Health England
  - Charing Cross Hospital
  - Newham Council
  - Bart's Hospital
  - Transport for London
  - St George's Hospital
  - Royal Mencap Society
  - Dynamic Training
  - The Pavilions Uxbridge
  - Northwick Park Hospital

West London Alliance

- Partnership between 7 West London Councils; Barnet; Brent; Ealing; Hammersmith and Fulham; Harrow, Hillingdon and Hounslow
- Hammersmith and Fulham Chair the West London Alliance Supported Employment Group which, utilising pooled 2019 Supported Employment Grant of respective Councils will focus or
- Improve communication and coordination of the 20 Supported Internships across West Londo
- Ensure that the funding of respective Supported Internships provides good value for money ar maximises employment outcomes
- Build on and further professionalise the Job Coaches engaged in Supported Internships and look to expand them to support adults in work
- Improve data and tracking of job outcomes both in Supported Internships and across the inclusive employment agenda
- West London Alliance are also working with Hammersmith and Fulham Council to develop a model for adults without an EHCP, who could utilise Personal Budgets to support their preparation for work and maximise the Department for Work and Pensions Access to Work programme thereafter

Next steps

- In order to maximise opportunities to develop and communicate pathways to employment for a range of residents requiring support, we will establish an Inclusive Employment Subgroup which will report to the recently established Employment and Skills Board
- The Inclusive Employment Subgroup will bring together services and providers supporting residents who require specialist help – this could include a mental and physical health issue or a learning disability (including autism). The Group will identify a number of ‘quick wins’ to better communicate support and services available and identify collaborative and inclusive approaches into support residents who want to work into work regardless of meeting traditional eligibility criteria.

Next steps continued

- Established Inclusive Employer Network meeting
- Met with NHS England in Feb 2020 to establish Pilot for LD and collaboration across NHS/LA
- Workshop to review Inclusive Employment Practices within Hammersmith and Fulham Council March 2020
- External evaluation of LBHF/L'Oréal Supported Internship
- Outcomes of Review of Economy further inform our collaborative working

London Borough of Hammersmith & Fulham

Report to: Health, Inclusion and Social Care Policy & Accountability Committee

Date: Wednesday, 4 March 2020

Subject: Work Programme

Report of: Bathsheba Mall

Summary

The Committee is asked to consider its work programme for the municipal year 2019/20

Recommendations

The Committee is asked to consider the proposed draft work programme (attached as Appendix 1) and suggest further items for consideration

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Wards Affected: All

H&F Priorities

Our Priorities	Summary of how this report aligns to the H&F Priorities
• Building shared prosperity	*In accordance with its constitutional terms of reference the work of the Committee will support the Council's priorities by helping to develop, shape and deliver health and social care services for the benefit of all borough residents.* *The Work Programme comprises of health and social care topics, ensuring an inclusive agenda of emerging and strategic policy areas.*
• Creating a compassionate council	
• Doing things with local residents, not to them	
• Being ruthlessly financially efficient	
• Taking pride in H&F	

Contact Officer:

Name: Bathsheba Mall
Position: Committee Co-ordinator
Telephone: 020 87535758 / 07776672816
Email: Bathsheba.mall@lbhf.gov.uk

Background Papers Used in Preparing This Report

None.

List of Appendices:

Committee Work Programme 2019/20

Appendix 1

Health, Inclusion and Social Care Policy and Accountability Committee
Work Programme Development Plan 2019/20

Item / working title	Overview / Development	Report Author / service
4 March 2020		
Specialist Palliative Care Provision	Continued monitoring of the engagement work currently being undertaken by the CCG on the provision of local palliative care services.	CCG
Supported Employment	To look at the opportunities for improving the provision of supported employment placements within the Borough and that development of guidance for this.	LBHF
24 March 2020		
SAEB	Presentation of LBHF, Safeguarding Adults Executive Board by the Chair, Mike Howard.	LBHF

Suggested items – included for information and discussion

- CAMHS update
- WLMHT update
- Health Based Places of Safety
- Immunisations
- Community Champions - to consider current provision and support, following disaggregation of the service and what this means for LBHF residents; to consider the further development and support of the service.
- Health and Public Transport for older residents
- The Digital Development of Primary Health Services – GP at Hand